PATIENT NAME____ DATE_______________

Welcome to our family! Kindly complete the following information so that we may offer you the best dental care possible.

Full Name ____ **Preferred** _____________ **Gender** ________

Address ____
Street City State Zip

Email ____________________________________ **DOB** __________ **Age** ______**SSN**__________________

Home Phone _________________ **Mobile** _________________ **Work** ______________ **Marital Status** ______

Insurance: __________________ ______________ ______________________ ______________
Carrier Name Phone # Policy/ID# Group #

Policy Holder: __________________________ ___________ ____________ ______________
Name DOB SSN Employer

Dental History

What is important to you in a dentist or dental practice? ____

How was your experience with the dentist in the past? ____

Date of last radiographs (x-rays) and exam ______________Date of last cleaning/periodontal treatment _____________

Former Dentist _________________________________

Reason/s for leaving previous dentist: ____

Are you experiencing any discomfort now? ☐ Yes ☐ No
If yes, please describe____

Have you ever been pre-medicated for dental treatment with antibiotics? ☐ Yes ☐ No

If yes, why? ____

What concerns do you currently have with your oral health or smile? ______________________________________

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Have you ever had periodontal (gum tissue) treatment, such as deep cleanings or periodontal surgery? ☐ Yes ☐ No

If yes, when? ____